STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	COMMISSIONER'S
OF	:	ORDER AND
WILLOW M. WOODWARD, M.D.	:	NOTICE OF HEARING

----------X

TO: Willow M. Woodward, M.D.
915 Niagara Street
Niagara Falls, New York 14503

The undersigned, Antonia C. Novello, M.D., M.P.H., Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by Willow M. Woodward, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12), that effective immediately Willow M. Woodward, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing

will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 1st day of October, 1999 at 10:00 A.M. at The Cambridge Hotel, 4 West Main Street, Cambridge, New York and/or at such other locations as determined by a committee on professional medical conduct and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in

writing to the Administrative Law Judge's Office, Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180 (518-402-0751), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
September 22, 1999

ANTONIA C. NOVELLO, M.D., M.P.H.
Commissioner

Inquiries should be directed to:

Timothy J. Mahar
Associate Counsel
NYS Department of Health
Division of Legal Affairs
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
WILLOW WOODWARD, M.D.	:	CHARGES

----------X

WILLOW WOODWARD, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 3, 1992, by the issuance of license number 189067 by the New York State Education Department. Respondent is currently registered with the New York State Education Department with a registration address of 915 Niagara Street, Niagara Falls, New York 14303.

FACTUAL ALLEGATIONS

A. During the period of June and/or July, 1999, Respondent was at times impaired for the practice of medicine and/or practiced medicine while impaired at Mary McClellan Hospital and associated health care facilities.

B. Respondent provided medical care to Patient A (Patients are identified by name in Appendix A) at the Mary McClellan Hospital in Cambridge, New York during a July 24, 1999 admission for urinary tract infection and vomiting, among other conditions. Respondent's medical care of Patient A deviated from accepted standards of medical care in the following respects:

1. On July 25, 1999, Respondent ordered "Morphine 25 mg IV now, place Narcan at the bedside" for Patient A, or used words of similar effect, which was excessive and/or inappropriate. Respondent subsequently changed

the order to "Demerol 25 mg IVP now", which was acceptable.

2. On July 24-25, 1999, Respondent failed to respond to or timely respond to multiple pages by the nursing staff regarding Patient A's medical status over an approximately five-hour period.

C. Respondent provided medical care to Patient B at Mary McClellan Hospital during a July 24, 1999 admission for fever, weakness and jaundice, among other conditions. Respondent's medical care of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or document an adequate physical examination of Patient B on July 24, 1999.

2. Respondent on July 25, 1999 gave the following two orders, or used words of similar effect, for Patient B each of which was inappropriate:

"25 mg Demerol 12 to 24 hours."

which Respondent changed to

"25 mg Demerol every four hours alternate with morphine every four hours."

Respondent subsequently changed the order a second time to Demerol 25 mg IM every four hours as necessary for pain, which was acceptable.

3. On July 24-25, 1999, Respondent failed to respond to or timely respond to multiple pages from the nursing staff regarding Patient B's medical status during an approximately five-hour period.

D. Respondent provided medical care to Patient C, who had a history of chronic obstructive pulmonary disease, at the Mary McClellan Hospital during a July 25, 1999 admission for hypoxia and congestive heart failure, among other conditions. Respondent's medical care of Patient C deviated from accepted

standards of medical care in the following respects:

1. Respondent failed to order an arterial blood gas for Patient C.

2. Respondent failed to perform and/or document an adequate physical examination of Patient C.

E. Respondent provided medical care to Patient D at the Mary McClellan Hospital during a July 25, 1999 admission for hypoxia, cellulitis of the legs, and congestive heart failure, among other conditions. Respondent's medical care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to order an arterial blood gas for Patient D.

2. Respondent failed to perform and/or document an adequate physical examination of Patient D.

F. Respondent provided medical care to Patient E on July 7, 1998, at the Olean General Hospital Emergency Room, in Olean, New York for complete heart block and hypotension, among other conditions. Respondent's medical care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to give appropriate orders regarding the administration of dopamine.

2. Respondent failed to give appropriate orders relating to the use of an external pacemaker.

3. Respondent failed to appropriately manage the resuscitation (cardiac code) of Patient E.

G. Respondent provided medical care to Patient F on July 8, 1998, at the Olean General Hospital Emergency Room, for atrial fibrillation among other conditions. Respondent's medical care of Patient F deviated from accepted standards of medical care in

the following respects:

1. Respondent ordered and administered Adenocard to Patient F which was inappropriate.

2. Respondent failed to initiate timely and/or appropriate treatments to slow Patient F's heart rate.

H. Respondent provided medical care to Patient G on July 10-11, 1998, at the Olean General Hospital Emergency Room, for cardiac arrest. Respondent's care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent ordered defibrillation of Patient G at a time when defibrillation was inappropriate and/or contraindicated.

I. Respondent provided medical care to Patient H on or about July 11, 1998, at the Olean General Hospital Emergency Room, for periods of apnea. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent ordered the administration of Mazicon, which was contraindicated.

2. Respondent failed to adequately assess Patient H.

J. Respondent provided medical care to Patient I on or about July 11, 1998, at the Olean General Hospital Emergency Room, for respiratory distress, among other conditions. Respondent's care and treatment of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent failed to appropriately treat Patient I following an initial treatment with

Proventil and Atrovent.

2. Respondent ordered the administration of epinephrine which was inappropriate.

K. On a medical license registration renewal application submitted by Respondent to the New York State Education Department on or about July 21, 1999 for the registration period of August 1, 1999 through July 31, 2001, Respondent made the following representations which Respondent knew or should have known were false:

1. That no hospital had restricted her employment or privileges since her last registration.

2. That she had not voluntarily or involuntarily resigned or withdrawn from an association with a hospital since her last registration to avoid imposition of restrictions or termination of hospital privileges due to professional misconduct, unprofessional conduct, incompetence or negligence.

L. On a pre-employment medical history form for Mary McClellan Hospital, Respondent made the following representations on or about June 2, 1999, which Respondent knew or should have known were false:

1. That she was not currently taking any medications.

2. That she was not under treatment for any illness at that time.

M. On March 3, 1999, Respondent submitted an application to Medina Memorial Hospital, Medina, New York, for medical staff and emergency department privileges. Respondent made the following responses and omissions to the application, which Respondent knew or

should have known were either false or incomplete:

1. That she had never voluntarily relinquished any medical staff membership, clinical privileges, or affiliation with any healthcare entity while under investigation, threat of investigation, or disciplinary action.

2. That her medical staff membership, medical staff status, or any other type of affiliation at any healthcare entity had never been suspended, diminished, not renewed, revoked or subjected to probationary condition or had proceedings toward any of those ends instituted or recommend by any official, committee, or governing body of any healthcare entity.

3. Respondent omitted her affiliation with Olean General Hospital in a response to an application question requesting, among other things, a list of all previous hospital affiliations.

SPECIFICATIONS

FIRST SPECIFICATION

Practicing While Impaired

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law Sec. 6530(7) by practicing the profession of medicine while impaired by alcohol, drugs, physical disability or a mental disability as alleged in the following factual allegations:

1. The facts set forth in Paragraph A.

SECOND SPECIFICATION

Impairment

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law Sec. 6530(8) in being a

habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, or having a psychiatric condition which impairs Respondent's ability to practice medicine as alleged in the following facts:

2. The facts set forth in Paragraph A.

THIRD THROUGH SIXTH SPECIFICATIONS

Gross Negligence

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the following factual allegations:

3. The facts set forth in Paragraphs B and B.1.
4. The facts set forth in Paragraphs F and F.3.
5. The facts set forth in Paragraphs H and H.1.
6. The facts set forth in Paragraphs I and I.1 and/or I and I.2.

SEVENTH THROUGH TENTH SPECIFICATIONS

Gross Incompetence

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law §6530(6) by practicing the

profession of medicine with gross incompetence as alleged in the following factual allegations:

7. The facts set forth in Paragraphs B and B.1.

8. The facts set forth in Paragraphs F and F.3.

9. The facts set forth in Paragraphs H and H.1.

10. The facts set forth in Paragraphs I and I.1 and/or I and I.2.

ELEVENTH SPECIFICATION

Negligence on More than One Occasion

Respondent is charged with professional misconduct as defined by Educ. Law §6530(3) by practicing medicine with negligence on more than one occasion as alleged in the following factual allegations:

11. The facts set forth in paragraphs B and B.1, and/or B and B.2, and/or C and C.1, and/or C and C.2, and/or C and C.3, D and D.1, and/or D and D.2, and/or E and E.1, and/or E and E.2, and/or F and F.1, and/or F and F.2, and/or F and F.3, and/or G and G.1, and/or G and G.2, and/or H and H.1, I and I.1 and/or I and I.2, and/or J and J.1, and/or J and J.2.

TWELFTH SPECIFICATION

Incompetence on More Than One Occasion

Respondent is charged with professional misconduct as defined by Educ. Law §6530(5) by practicing medicine with incompetence on more than one occasion as alleged in the following factual allegations.

12. The facts set forth in paragraphs B and B.1, and/or B and B.2, and/or C and C.1, and/or C and C.2, and/or C and C.3, D and D.1, and/or D and D.2, and/or E and E.1, and/or E and E.2, and/or F and F.1, and/or F and F.2, and/or F and F.3, and/or G and G.1, and/or G and G.2, and/or H and H.1, I and I.1 and/or I and I.2, and/or J and J.1, and/or J and J.2.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

Fraudulent Practice

Respondent is charged with professional misconduct as defined by Educ. Law §6530(2) by reason of her practicing medicine fraudulently, as alleged in the following factual allegations:

13. The facts set forth in Paragraphs K and K.1, and/or K and K.2;

14. The facts set forth in Paragraphs L and L.1, and/or L and L.2;

15. The facts set forth in Paragraphs M and M.1, and/or M and M.2, and/or M and M.3.

SIXTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

Moral Unfitness

Respondent is charged with professional misconduct as defined by Educ. Law §6530(20) by reason of practice conduct which evidences moral unfitness to practice medicine, as alleged in the facts of the following:

16. The facts set forth in Paragraphs K and K.1, and/or K and K.2;

17. The facts set forth in Paragraphs L and L.1, and/or L and L.2;

18. The facts set forth in Paragraphs M and M.1, and/or M and M.2, and/or M and M.3.

NINETEENTH THROUGH TWENTY-FIRST SPECIFICATIONS

Filing A False Report

Respondent is charged with professional misconduct as defined in Educ. Law §6530(21) by reason of having willfully made and filed a false report as alleged in the following factual allegations:

19. The facts set forth in Paragraphs K and K.1, and/or K and K.2;

20. The facts set forth in Paragraphs L and L.1, and/or L and L.2;

21. The facts set forth in Paragraphs M and M.1, and/or M and M.2, and/or M and M.3.

TWENTY-SECOND THROUGH TWENTY-FOURTH SPECIFICATIONS

Record Keeping

Respondent is charged with professional misconduct as defined by N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the following factual allegations.

22. The facts set forth in Paragraphs C and C.1.

23. The facts set forth in Paragraphs D and D.2.

24. The facts set forth in Paragraphs E and E.2.

DATED: September 22, 1999
Albany, NY

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct